

VERIFICATION OF A COLLABORATIVE AGREEMENT FOR PRESCRIPTIVE WRITING PRIVILEGES

(Complete for each collaborative physician)

I _____ (license number _____ /RXA number _____) certify by my signature that a written collaborative agreement exists between myself and Dr. _____ (license number _____), and that written guideline/protocols for prescriptive practice are signed and in place. My collaborative agreement with Dr. _____ begins on _____, expires on _____ (cannot exceed expiration date of 06/30/2015) and expires with termination of my employment. Both myself and the above named physician have read and understand the regulations pertaining to prescriptive writing privileges (Federal and State prescribing laws including West Virginia Code for Registered Professional Nurses '30-7-15a,b,c; '30-15-7a,b,c for midwives; and West Virginia Legislative Rule '19CSR8). I understand that for prescriptive writing privileges, the collaborative agreement includes, but is not limited to, the following:

(Please check to indicate completion)

1. Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the advance nurse practitioner's prescriptive practice. I have listed below protocols the guidelines and protocols used in my practice.

2. Statements describing the individual and shared responsibilities of the advanced nurse practitioner and the physician pursuant to the collaborative agreement between them are listed below:

3. Periodic and joint evaluation of prescriptive practice will occur as listed below:
Frequency of record review _____ Number of records reviewed _____; and
4. Periodic and joint review and updating of the written guidelines or protocols will occur _____ (frequency).

Prescriptive Authority Verification
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I further understand that I must assure that current information regarding collaborative agreement(s) is on file at the Board office. I understand that I must have at least one current collaborative agreement verification on file at the Board office at all times. When my collaborative agreement is no longer valid (i.e. dissolution of agreement, agreement not renewed, termination of my employment), I understand that I am to notify the Board office immediately. I further understand that my prescribing privileges are for practice only in the state of West Virginia and that my prescribing practice may be audited/reviewed by the Board. I will practice according to Federal and State Law, the standards of practice in my specialty area, my education and documented competence.

Furthermore, I, the undersigned, being duly sworn, according to law, do depose and say that I am the person making this application; that the statements therein are true to the best of my knowledge and belief; that I have read and understand the Law and Rule pertaining to prescriptive authority; I understand that failure to comply with requirements for licensure, and that knowingly supplying false information on or with this verification is a violation of WV Code §30-7-1 et seq. and subjects me to the full range of disciplinary action described therein.

Name of Applicant: _____

Practice Address: _____

Phone: _____

_____ Fax: _____ Email: _____

Name of Physician: _____

Practice Address: _____

Phone: _____

_____ Fax: _____ Email: _____

Applicant's Signature _____ Date: _____

Physician's Signature _____ Date: _____

SUBSCRIBED AND SWORN TO BEFORE ME this ____ day of _____, 20__

My commission expires _____

(SEAL)

Notary Public